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RESPONSES AND DIALOGUE

The Moral Bindingness of Advance Directives

A Response to Steve Latham, "Commentary: On the Moral Blindingness of Advance Directives" (CQ 29 (1))

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Professor Latham has written a thought-provoking commentary[1] on my paper about advance directives.[2] I am grateful for this opportunity to integrate the debate on the moral binding nature of these manifestations of will.

As correctly inferred by Latham, under Italian law, not only are advance healthcare directives applied to refuse or request a given form of lifesaving or life-sustaining treatment (which is the case in the United States), but also to refuse or accept any form of treatment deemed useful and legally applicable, in accordance with medical ethics precepts, in cases where patients are temporarily unconscious.[3] Such a different scope of application of advance directives has a bearing on any judgment as to the binding or nonbinding nature of such expressions of patient will. It is, however, doubtful that the somewhat narrow scope of application of advance directives in the United States may justify their binding nature.

As for the argument set forth by Latham, with reference to his 80-year-old mother, I doubt that it would be enough to merely inform her that the chance of survival in cases of cardiopulmonary resuscitation (CPR) following cardiac arrest is as low as 15%. Making a cogent decision does require much more thoroughly detailed information. As a matter of fact, the odds of success are closely linked to the timing of the medical intervention itself: "Defibrillation within 3–5 min of collapse can produce survival rates as high as 50%–70%."[4] Furthermore, the type of condition calling for CPR is a determining factor: in patients with heart conditions, being treated for cardiovascular diseases, resuscitation success rates are above average, at 70%. On the other hand, for patients with underlying conditions other than cardiovascular diseases, resuscitation procedures often prove useless: in such instances, in fact, cardiac arrest is only the climax, occurring as a result of major systemic failure.[5] That arguably entails that it is somewhat immaterial (in addition to uninformed) to express a refusal of a given treatment without specifying a real scenario and its related benefit-cost ratio. Undoubtedly, the obligation to provide information is more easily discharged if the patient needs immediate care. In fact, in such cases, doctors only have to make patients acquainted with the benefit-cost ratio inherent to the medical treatment, possible viable alternatives, and consequences of a refusal. Conversely, through advance directives, patients can refuse treatment options that may prove necessary because of various different conditions, with varying benefit-cost ratios for each disease.

Moreover, the benefit-cost ratio for each treatment may vary based on (1) how old the patient will be when said treatment is necessary; (2) the presence of comorbidities; and (3) predictable case characteristics, for example, the time period between cardiac arrest and CPR.

Such a higher degree of complexity, however, does not necessarily foreclose the use of advance directives. The main objective of figuring out what the patient's will would have been, in fact, may be achieved by construing and interpreting the directive's contents in a logical fashion, according to common sense. For instance, let us imagine that a patient refused a form of treatment through an advance directive outlining a hypothetical real-life scenario (i.e., type of disease, patient's age, timely medical intervention, etc.) presenting a favorable benefit-cost ratio. If, however, a different future

situation should come into being, with a treatment presenting a more unfavorable benefit-cost ratio, it would be reasonable to infer that the patient would refuse it, in light of the worse odds (although the advance directive did not comprise such a contingency). Hence, it appears necessary for doctors to thoroughly inform their patients as to the benefit-cost ratio of any healthcare treatment related to a given disease or comorbidities; on the other hand, any shortcoming an advance directive may have does not necessarily entail its inapplicability: advance directives must be complied with if, under the case circumstances and according to logical standards of common sense, it is obvious what decision the patient would have made, had he or she been capable of doing so.

In light of the above, I feel it is reasonable to expect that doctors ought to weigh the degree of probability by which patients should undergo a given treatment that was refused through an advance directive. A healthy 80-year-old, for instance, who chooses to refuse a treatment through an advance directive, needs to carefully mull over such a choice because he or she is aware of the fact that the same treatment may become necessary in due time. In addition, given the patient's advanced age, he or she may already be familiar with the concept of physical limitations, or even disability. Probably, on the other hand, a young, healthy, unmarried patient without children would draft that same directive with a lower degree of attention and awareness. Such considerations would lead me to believe that advance directives are not to be deemed intrinsically binding, not even in cases of artificial nutrition, hydration, or ventilation following loss of consciousness: Decision-making based on a case-by-case analysis will always be essential, although in such instances it may be much easier to decide in favor of applying the directive. That is in my view the ultimate effect arising from the narrower scope of application of advance directives in the United States, rather than the necessarily binding nature thereof.

I agree with taking into account each individual patient's conditions, for example, whether a demented patient is deemed "happy" or "miserable," since in the latter case, "it is more likely that the patient's current interests are not in conflict with his earlier-expressed preferences."[6] The refusal of treatment, as outlined in the advance directive, should therefore be complied with, according to Latham. Yet, what takes me aback is the notion that doctors may apply the "more likely than not" standard when making decisions on which the patient's life may depend. Why, in fact, is it necessary to provide certainty beyond the reasonable doubt just to levy a fine, whereas all it takes to legally refrain from saving a patient's life is the higher likelihood that the refusal expressed in the directive would have been confirmed by the patient, had he or she be competent to do so? Requiring evidence beyond the reasonable doubt prior to imposing criminal sanctions is one of the tenets of our current legal civilization. So it is, in my opinion, demanding indisputable evidence before deciding whether to withdraw or withhold lifesaving treatments.

I do not feel that such a high standard would be tantamount to discounting advance directives to "bug" status,[7] but rather represents the enforcement of rules meant to avoid the most irreparable damage: loss of life. Applying an advance refusal that does not match the will which the patient would have expressed, had he been competent, is in my opinion a more serious mistake than failing to abide by an advance refusal that reflects the patient's current will. The former mistake in fact translates into irreparable damage, the patient's death, which cannot be reversed, and for which any form of compensation would benefit not the patient, obviously, but his or her family; the latter mistake, on the contrary, may be effectively reversed through the withdrawal of life-sustaining treatment at a later time, or through the award of compensatory damages.

Notes

1. Latham S. Commentary: On the moral bindingness of advance directives. *Cambridge Quarterly of Healthcare Ethics* 2020;**29**(1):110–14.
2. Montanari Vergallo G. Advance healthcare directives: Binding or informational value? *Cambridge Quarterly of Healthcare Ethics* 2020;**29**(1):98–109.
3. Section 1, Subsections 5 and 6; Section 4, Subsection 1, Italian law 22 Dec 2017, no. 219; available at https://www.gazzettaufficiale.it/eli/id/2018/1/16/18G00006/sg (last accessed 5 Jan 2023).

4. European Resuscitation Council. *Guidelines for Resuscitation 2015*; available at https://ercguidelines.elsevierresource.com/european-resuscitation-council-guidelines-resuscitation-2015-section-1-executive-summary, at 2 (last accessed 5 Jan 2023).
5. Swiss Academy of Medical Sciences. *Decisioni in merito alla rianimazione*; 2017; available at https://www.samw.ch/dam/jcr:f97e4bea-af47-461c-8389-695119c88e81/direttive_assm_rianimazione.pdf, at 12 (last accessed 5 Jan 2023).
6. See note 1, Latham 2020, at 114.
7. See note 1, Latham 2020, at 112.

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